CHAPTER 1

GENERAL

A. INTRODUCTION

1. Purpose

a. The purpose of the Medical Expense and Performance Reporting System (MEPRS) for DoD Medical Operations is to provide a uniform healthcare cost management system for the Department of Defense. The MEPRS also provides detailed, uniform performance indicators, common expense classification by work centers, uniform reporting of personnel utilization data by work centers, and a cost assignment methodology.

b. The MEPRS is the basis for establishing a uniform reporting methodology that provides consistent financial and operating performance data to assist managers who are responsible for healthcare delivery in the fixed military medical system.

c. The MEPRS defines a set of functional work centers, applies a uniform performance measurement system, prescribes a cost assignment methodology, and obtains reported information in a standard format for each fixed medical treatment facility. Resource and performance data must reflect the resources used in delivering healthcare services; be recorded on a current, accurate, and complete basis in sufficient detail to permit management review and audit of the recorded and reported data; and comply with MEPRS functional work center requirements.

2. Responsibility

a. Responsibility for policy guidance and the implementation, issuance, and maintenance of the MEPRS is as indicated:

(1) The Assistant Secretary of Defense for Health Affairs shall exercise management, direction, and maintenance of the MEPRS within the Department of Defense.

(2) The Under Secretary of Defense (Comptroller)/Chief Financial Officer shall provide financial management policy, guidance, and instructions to DoD Components on financing, budgeting, and accounting for all healthcare resources within the Department of Defense.

(3) The Under Secretary of Defense for Personnel and Readiness (USD(P&R)) shall provide general manpower management policy guidance and instruction to DoD Components.

(4) The DoD Components shall:

(a) Implement the provisions of this Manual.

(b) Develop and report uniform and comparable data.

b. All the principals mentioned in A.2.a., above, shall coordinate their efforts to ensure that the MEPRS is consistently implemented and integrated into existing management systems.

3. Objectives

a. The MEPRS provides military healthcare management with a uniform system for managing and reporting on the fixed military healthcare delivery system.

b. This Manual provides guidance to ensure consistent identification, recording, accumulation, and reporting of data from fixed military medical system activities *and operations. Information* provided *by* the MEPRS assists in measuring productivity and management effectiveness, developing performance standards, developing program estimating equations, and identifying areas requiring management emphasis. In addition, the MEPRS provides a means of identifying facility and system medical capability and indicates actual and potential areas for interservice support of medical workload.

4. Interpretations and Recommendations

Requests for information, clarification, or interpretation of, or changes to this Manual shall be submitted to the Office of the Assistant Secretary of Defense for Health Affairs OASD(HA). Deviations from this Manual *must be* submitted for *approval to* *O.ASD.(HA)* *after coordinating the overall* DoD effect of such a deviation with the other Military Departments. Other matters, such as proposed modifications of the Manual, shall be submitted in accordance with chapter 5.

5. Information Requirements

Report Control Symbol DD-HA(M)1704 has been assigned to the reporting requirements contained in this Manual.

6. Standardization Compliance

In accordance with DoD 8326.1-M (reference (a)), all the data elements contained in this Manual shall be standard for DoD application. Other data elements and codes are interim (nonstandard) and have been registered in the program pending standardization. The OASD(HA) is the office responsible for ensuring that MEPRS data elements comply with DoD Directives.

B. OVERVIEW AND CONCEPT

1. Overview

The Uniform Chart of Accounts (UCA) and the Uniform Staffing Methodologies (USM) systems were developed and implemented separately within the Military Health Services System (MHSS) . The UCA system grew out of the need to track expenses within the military healthcare facilities, and its development and implementation was under the direction of the OASD(HA) in conjunction with the Military Services' medical comptrollers and/or resource managers. The USM system was concerned with manpower resources; and OASD(HA) , in conjunction with cognizant Military Service Medical manpower personnel, developed, and implemented the USM system. At the military treatment facility (MTF) level, it became evident that the most effective and efficient utilization of personnel recording data for the two systems was to merge the data capture function and ultimately the two systems. Under the direction of OASD(HA) and in con-junction with tri-Service manpower and comptroller personnel., preparation began in January 1985 to merge the two systems, and was completed in fall 1985. The MEPRS Manual was effective commencing with the processing of first quarter fiscal year (FY) 86 expense and performance data and was mandatory for use by all DoD Components.

2. **UCA Background**

a. In August 1973, the Office of Management and Budget; the Department of Defense; and the Department of Health, Education, and Welfare, by Presidential mandate, initiated a joint study of the military healthcare system. The four principal concerns providing the impetus for this study *were:*

(1) Anticipated physician shortages associated with ending the draft.

(2) Increased overhead and support costs throughout the Department of Defense.

(3) The quality of systems for planning, management, and evaluation.

(4) The social equity of 'military medical care and its compatibility with national healthcare objectives.

b. Results of the study *were* published in December 1975, following an intensive 2 1/2 year effort. Nine major recommendations were made for more effective and efficient delivery of military healthcare services in the Continental United States (CONUS) fixed military medical facilities during peacetime. From these recommendations came the need for a *uniform* data system within the three Military Medical Departments. The following specific findings were reported:

(1) Separate and independent information systems and databases were being maintained.

(2) Different interpretations of the definitions of common data elements were being made.

(3) Inconsistencies, definition problems, and noncomparable inputs providing three divergent output modes.

(4) Valid comparisons of systems operations could not, therefore, be made.

c. In developing the UCA, consideration was given to the existing accounting and reporting systems that were in place and functioning within the Military Medical Departments. Differences in military missions, systemsizes, hospital sizes, fiscal and financial structures, reporting authorities, reporting requirements, and other distinguishing factors were taken into consideration. In considering an integrated military accounting and reporting system, the following components were identified as essential:

(1) Uniform Chart of Accounts.
(2) Performance Measurement.
(3) Reporting.

3. **USM Background**

a. In 1974, and again in 1976, the House Appropriations Committee recommended that the Department of Defense develop and use uniform standards in determining medical manpower requirements. Congress desired the ability to compare the Military Services' medical manpower determinants and costs. In response to those recommendations, the ASD(HA) developed a project to examine, refine, and improve the Air Force system of programming medical manpower requirements . From the work accomplished during 1976, a project to develop

the USM across the medical departments of the Army, Navy, and Air Force evolved. In September 1977, the OASD(HA) developed a working paper, Determining a Uniform Methodology for Medical Manpower Requirements Planning (reference (b)), which outlined the means by which a uniform staffing methodology could be achieved.

b. The working group was formed in 1978 to begin the development of a uniform methodology. Established approaches employed by the Military Services were reviewed and analyzed, common work center descriptions were tentatively approved, and work on the development of a uniform-medical manpower reporting system was begun. In addition, this effort was aligned with the UCA.

c. The USM's impact on the individual medical services was through program estimating equations developed from the Uniform Staffing Report with a formula and coefficients specific to each medical service. While the approach or method to develop the estimating equations will be the same for all Military Services, the data used to develop them, as well as the resulting formulas and coefficients were Service-unique. Changes in workload factors (such as population, patient days, and visits) were applied to the functional estimating equations to determine macro requirements (such as total Service pharmacy manpower requirements) . Beyond this, each Military Service determined grade and specialty mix.

d. By utilizing a common methodological basis, the three Military Departments used a uniform, scientifically derived tool for determining, budgeting, defending, and allocating basic requirements. With this uniform tool , long-range forecasting techniques be developed.

4. Concept

a. During peacetime, the MHSS must be concerned primarily with establishing, maintaining, and improving its capability to respond to national security requirements, and secondarily with cost, efficient staffing, economic use of resources, establishment of measurable and achievable objectives, and healthcare planning. Predominant requirements and related systems fulfill national security requirements and balance the peacetime requirements. Within these constraints, a constant effort must be made to accumulate the necessary expense and performance data and analysis so that each management level can identify, define, correct, or improve its normal, peacetime healthcare delivery system. There is also a need to specify individual and group responsibility and accountability, as well as financial accountability in terms of resources that are available, used, and expended.

b. The MEPRS assists managers at all levels in these processes, in critical decision–making, and in performance evaluation. Managers need current, accurate, and complete quantitative data for decision-making, comparing actual performance with objectives, analyzing significant deviations, and taking corrective action. The MEPRS is a system of manpower and cost distribution and expense reporting that provides management with a basic framework for responsibility accounting and the flexibility to categorize financial information of functional activities that may cross organizational lines.

c. Increased concerns about defense expenditures., the national focus on the escalation cost of health services, and the perception that management of the MHSS can be improved suggest that a single expense and manpower system is necessary. The use of uniform classifications, uniform methods, workload, and definitions provides a common standard measurement, makes comparisons more meaningful, and provides a basis to make better, more equitable resource decisions in the operation of the MHSS. Not only shall

comparisons among similar Army, Navy, and Air Force MTFs be possible, but comparisons with the civilian health sector shall be facilitated. The following benefits are expected to result from the appropriate use of the MEPRS :

(1) Cost awareness.

(2) More current, accurate, and complete expense information.

(3) Expense assignment to the primary work center that incurs the cost of performing a healthcare service.

(4) Cost-effectiveness evaluation.

(5) Manpower utilization management information.

(6) More effective decision-making related to cost or performance.

(7) Better comparisons among military medical facilities and with the civilian health sector.

(8) Reliable and relevant management information system.

C. **ORGANIZATION OF THIS MANUAL**

This Manual is divided into five chapters and six appendices as follows:

1. Chapter 1, General.

2. Chapter 2, Chart of Accounts.

a. Functional Categories. The sections of this chapter are arranged by MEPRS code functional categories, the hierarchy of accounts in which all expenses and corresponding workload data are collected. The functional categories are as follows: Inpatient Care; Ambulatory Care; Dental Care; Ancillary Services; Support Services; Special Programs; and Readiness.

b. Summary and Subaccounts. Each of the functional categories is further divided into summary accounts-and subaccounts. The subaccounts are accumulated into their corresponding summary account. An example of this hierarchical arrangement is as follows:

Inpatient Care (Functional Category)
Medical Care (Summary Account)
Internal Medicine (Subaccount)
Cardiology (Subaccount)

c. Final and Intermediate Accounts. It should be noted that the inpatient care, ambulatory care, dental care, special programs, and readiness accounts are considered to be final operating expense accounts, as defined in the glossary at Appendix A. Ancillary services and support services accounts are intermediate operating accounts, whose expenses are reassigned to the final operating expense accounts, as explained in Chapter 3.

3. Chapter 3, Manpower and Expense Assignment. This chapter defines a basis for distributing accumulated salaries and costs to the inpatient, outpatient, dental, ancillary, special programs, and readiness accounts. In other words, all ancillary and support services expenses and salaries must be included in the operating expense account (work center) responsible for incurring the expense or utilizing the work-hours. Similarly, workload shall

be recorded within the operating expense account, where related expenses or work-hours are incurred. The operating expenses and salaries accumulated in the intermediate expense accounts are reassigned in a sequential (stepdown) process to the final operating expense accounts. It is important to recognize that this process applies only to the reassignment of expenses and does not permit the reassignment of workload data contained in the ancillary and support services accounts. The alignment of the accounts in Chapter 3 is the sequential order in which each account is to be reassigned. It should be further noted that as the expenses in each account are reassigned the account is considered closed during the remainder of the stepdown process.

4. Chapter 4, Reporting Requirements. The primary report is the DoD Medical Expense and Performance Report (MEPR). The Expense Assignment System, in addition to generating the MEPR, has the capability to generate other reports.

5. Chapter 5, MEPRS Issue Process. The MEPRS Manual is subject to change, refinement, and clarification over time. The Issues System discussed in Chapter 5 is designed to keep the Manual current with new developments and techniques and to ensure uniformity of interpretation and application by military medical treatment facilities.

6. Appendix A, Glossary. The glossary includes the terms considered essential to the understanding and implementation of the Medical Expense and Performance Reporting System (MEPRS). Many definitions have been rewritten with certain subtle constraints or changes to accommodate a tri-Service understanding and use. Users are cautioned to read this appendix with particular care.

7. Appendix B, Standard Account Codes. This is a list of the standard MEPRS codes. Except for changes made by the Department of Defense, these codes may not be altered or modified at the first, second, or third levels- The only exception to this rule is cost pools, which may be created locally. Codes that have a "z" in the third position are used to collect data for special circumstances, such as bone marrow transplant, before a separate code is established. Use of these codes (e.g., AAZ, ABZ, etc.) must be approved at the Service Headquarters level and is time-limited.

8. Appendix C, Weighted Procedures. Unweighed performance (workload) measurement has been used as an output measure within the military medical system for a number of years. Such-measurement does not accurately reflect output or productivity since it does not consider consumption of resources or relative complexity and costliness of workload performance. This appendix specifies or references weighted values to be used in measuring output of certain work centers.

9. Appendix D, Medical Expense and Performance Report Data Elements. This appendix comprises a listing of MEPR data elements, most of which have been registered or standardized in the DoD Data Element Program.

10. Appendix E, Standard Stepdown Assignment Statistic (SAS) Numbers. SAS identification numbers to be used in the Expense Assignment System (EAS) are contained in this appendix.

11. Appendix F, Guidelines for Available and/or Nonavailable Time Within a Fixed Medical and Dental Facility. This appendix provides guidelines for collecting and reporting available and nonavailable time.